

# KANSAS MEDICAID STATE PLAN

Replacement Page

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## Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

### 6.2000 (Continued)

- B6. Hospital revenue from Medicare worksheet G2, column 3, total patient revenue (line 25) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8) - HHA (line 19) - Ambulance (line 20) - CORF (line 21) - ASC (line 22) - Hospice (line 23).
- B7. Cost to revenue ratio (B5 / B6).
- B8. Hospital revenue attributable to the inpatient portion of State and local government funds (B4 / B7).
- B9. Unduplicated charity care charges (B1 - B8. If this is negative, use 0).
- B10. Ratio of unduplicated charity care to total inpatient revenue (B9 / A5).
- C1. Low-Income utilization rate (A11 + B10).
- D1. Uninsured Charges. The uninsured are only those patients shown in charity care (B1) for which no other payment is received.

### Payment Adjustment

If the low-income utilization rate in C1 above exceeds 25%, then the excess over 25% shall be multiplied by 10 and the resulting number shall be multiplied by the amount of Kansas Medicaid/MediKan (excluding prior disproportionate share payments) payments for services received in the State Fiscal Year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example 1993 state fiscal year payment adjustment shall be based upon state fiscal year 1991 Kansas Medicaid/MediKan annual payment.

An example of both the eligibility and payment adjustment computations are attached.

### 6.3000 Simultaneous Option 1 and Option 2 Eligibility

If a hospital is eligible under both 6.1000 and 6.2000, the disproportionate share payment adjustment shall be the greater of these two options.

### 6.4000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000 or 6.2000, a hospital may request in writing a review of the determination within 30 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

### 6.5000 Payment Limitations

If the payments determined exceed the allotment determined by HCFA in accordance with section 1923(f)(1)(c) of the Social Security Act, then all hospitals eligible for disproportionate share shall have their disproportionate share payments reduced by an equivalent percentage which will result in an aggregate payment equal to the allotment determined by HCFA.

All hospitals are limited to no more than 100% of the cost of the uninsured plus the difference between the cost of Kansas Medicaid inpatient services and the payments for Kansas Medicaid services. Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

Submitted for review 10/20/95 dated 1/23/97

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If the hospital is a public hospital (State, city, county or district), then the payments determined above are further limited. Unless the hospital qualifies as a high DSH, payments made during a fiscal year shall not exceed the cost incurred by a hospital for furnishing hospital services to Medicaid recipients less non DSH and to uninsured patients less patient payments. In the case of a hospital with a high disproportionate share, payments made during a fiscal year shall not exceed 200% of the amount described above. To be considered a high DSH, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or have the largest number of Medicaid inpatient days of any hospital in the State in the previous fiscal year. Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

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Department of Social and Rehabilitation Services

## Disproportionate Share Low-Income Utilization

All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar references.

Hospital Name \_\_\_\_\_

Kansas Medicaid Number \_\_\_\_\_ Fiscal Year Ending \_\_\_\_\_

A1 Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payemnts.  
Contact SRS Medical Fiscal (913-296-3981) for a log summary.

Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))

A2 \_\_\_\_\_

A3 \_\_\_\_\_

A4 Total Medicaid/Medikan, State and local government funds.  
(A1 + A2 + A3) \_\_\_\_\_

A5 Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8)) \_\_\_\_\_

A6 Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3) \_\_\_\_\_

A7 Ratio of inpatient revenues to total patient revenues ( $A5 \div A6$ ) \_\_\_\_\_

A8 Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2) \_\_\_\_\_

A9 Inpatient share of contractual allowances and discounts ( $A7 \times A8$ ) \_\_\_\_\_A10 Net inpatient revenue ( $A5 - A9$ ) \_\_\_\_\_

A11 Ratio of Medicaid/Medikan, State and local government funds to net inpatient revenue ( $A4 \div A10$ ) \_\_\_\_\_

B1 Inpatient charity care charges. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spendown incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review.

B2 Other State and local government funds ( $A2 + A3$ ) \_\_\_\_\_

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B3	Ratio of inpatient revenues to total patient revenues (A7)	_____
B4	Inpatient portion of State and local government funds (B2 × B3)	=====
B5	Hospital costs (Medicare Worksheet B Part I, Total Column, Subtotal (Line 95)) - SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Ambulance (Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93))	_____
B6	Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC (Line 22) - Hospice (Line 23)	_____
B7	Cost to revenue ratio (B5 ÷ B6)	_____
B8	Hospital revenue attributable to the inpatient portion of State and local government funds (B4 ÷ B7)	=====
B9	Unduplicated charity care charges (B1 - B8 (if negative use 0))	=====
B10	Ratio of unduplicated charity care to total inpatient revenue (B9 ÷ A5)	=====
C1	Low-Income utilization rate (A11 ÷ B10)	=====
	The section below only applies if C1 exceeds 0.25. If C1 exceeds 0.25 (25%), then the hospital is eligible for a disproportionate share payment as computed below (subject to verification).	
C2	Excess over 25% (C1 - 0.25)	_____
C3	Ten times the excess over 25% (C2 × 10)	_____
C4	Kansas Medicaid/Medicaid inpatient payments for services rendered in the State fiscal year ending two years prior to the year of the disproportionate share payment, excluding previous disproportionate share payments. (See attached schedule)	_____
D1	Hospital Limitation. All hospital are limited to no more than 100% of their net Medicaid cost plus uninsured for FY 1996. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. Report the uninsured here. Do not report Medicaid here. SRS shall compute the Medicaid limitation. This line must be completed by all hospitals or no disproportionate share payments will be made.	=====
D2	Estimated disproportionate share computation (Lesser of D1 or C3 × C4)	=====

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.

\_\_\_\_\_  
Signature of Officer/Administrator

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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7.0000 Change of Ownership

7.1000 Department Notification and Provider Agreements

- a. Each hospital shall notify the Department in writing at least 60 days prior to the effective date of the change of ownership. Failure to do so shall result in the forfeiture of rights to payment for covered services provided to recipients by the previous owner or owners in the 60 day period prior to the effective date of the change of ownership. Failure to notify the Department in writing at least 60 days prior to the effective date of the change of ownership shall result in the new owner or owners assuming responsibility for any overpayment made to the previous owner or owners before the effective date of the change of ownership. This shall not release the previous owner of responsibility for such overpayment. This notification requirement may be waived at the discretion of the Department based upon the showing of good cause by a hospital changing ownership. The new owner or owners shall submit an application to be a provider of services in the program and shall not receive reimbursement for covered services provided to recipients from the effective date of the change of ownership until the date upon which all requirements for participation pursuant to state regulations have been met or until the date upon which an application to be a provider of services in the program is received by the Department, whichever comes later.
- b. At least 60 days before the dissolution of the business entity, the change of ownership of the business entity, or the sale, exchange or gift of 5% or more of the depreciable assets of the business entity, the Department shall be notified in writing. If the business entity fails to provide 60 days written notice, no reimbursement shall be made. This notification requirement may be waived at the discretion of the Department based upon the showing of good cause by a hospital changing ownership.
- c. If a sole proprietor not incorporated under applicable state law transfers title and property to another party, a change of ownership shall have occurred. An application to be a provider of service shall be submitted to the Department by the new owner and affiliated providers.
- d. Transfer of participating provider corporate stock shall not in itself constitute a change of ownership. Similarly, a merger of one or more corporations with the participating provider corporation surviving shall not constitute a change of ownership. A consolidation of two or more corporations which creates a new corporate entity shall constitute a change of ownership, and an application to be a provider of services shall be submitted to the Department by the new owner and affiliated providers.

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7.1000 continued

- e. Each partnership that is dissolved shall not require a new provider agreement if at least one member of the original partnership remains as the owner of the facility. Each addition or subdivision to a partnership or any change of ownership resulting in a completely new partnership shall require that an application to be a provider of services be submitted to the Department by the new owner and affiliated providers.
- f. The change of or creation of a new lessee, acting as a provider of services, shall constitute a change of ownership. An application to be a provider of services shall be submitted to the Department by the new lessee and affiliated providers. If the lessee of the facility purchases the facility, the purchase shall not constitute a change in ownership.

7.2000 Certification Surveys

Each new owner or owners shall be subject to certification by Medicare.

7.3000 Cost Limitations

- a. For each asset in existence on July 18, 1984, which is subsequently sold, the valuation of the asset for reimbursement purposes shall be the lesser of the allowable acquisition cost of the asset to the owner of record on July 18, 1984, or the acquisition cost of the asset to the new owner.
- b. For each asset not in existence on July 18, 1984, the valuation of the asset for reimbursement purposes shall be the lesser of the acquisition cost of the asset to the first owner of record or the acquisition cost of the asset to the new owner.
- c. Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, shall not be allowable.

8.0000 Audits

The Department shall perform any reviews or audits deemed appropriate to insure the reasonableness of the cost of reimbursed services. The Department shall continue to receive information from the fiscal intermediaries of Medicare under the common audit agreement which shall identify costs incurred and which will allow for comparisons to be made to the payment which would have been made under the existing Medicare cost reporting system.

Kansas Medicaid Plan

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9.0000 Public process for proposed changes in methods and standards for establishing payment rates - inpatient hospital care. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.



KANSAS DEPARTMENT OF SOCIAL  
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

December 22, 1995

Mr. Richard P. Brummel  
Health Care Financing Administration  
Federal Office Building  
601 East 12th Street  
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253 the Department of Social and Rehabilitation Services submits the following assurances to Kansas Medicaid payments for general hospital services. This assurance relates to MS-95-21 regarding the reimbursement methodology for general hospital inpatient services.

1. Payment Rates

42 CFR 447.253(b)(1)(i)

Payment rates are reasonable and adequate to meet the costs that must be incurred by efficiency and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 CFR 447.253(b)(1)(ii)(A)

The methods and standards used to determine payment rates take into account the situations of hospitals which serve a disproportionate number of low income patients with special needs. Hospitals are determined to be disproportionate share hospitals and payments are computed according to the methodology described in Attachment 4.19A, Section 6.0000.

42 CFR 447.253(b)(1)(ii)(B)

Services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services are paid at rates lower than those for inpatient hospital level of care services.

42 CFR 447.253(b)(1)(ii)(C)

The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 CFR 447.272(c)

Aggregate disproportionate share payments do not exceed the disproportionate share base allotment. Disproportionate share payments to public facilities will not exceed the limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993).

Mr. Richard P. Brummel  
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Social Security Act, Section 1902(a)(13)(B)

Kansas assures that payment rates to providers will not be increased by capital-related costs due solely to a change of ownership which occurs on or after July 18, 1994, in excess of the amount that would be permitted under the provision of Section 1816(v)(2)(O) of the Act.

## 2. Upper Payment Limits

42 CFR 447.253(b)(2)

The payment rates do not exceed the upper payment limits as specified in 42 CFR 447.272.

The State assures that aggregate payments made to each group of State-operated facilities, when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles as required by 42 CFR 447.272(b)

## 3. Provider Appeals

42 CFR 447.253(e)

The State in accordance with federal and state regulations assures that a fair hearing, appeal or exception procedure allowing for an administrative review and appeal by a provider is provided for payment rates.

## 4. Uniform Cost Reporting and Audit Requirements

42 CFR 447.253(f) and (g)

Hospitals are required to file annual cost reports with Medicare. Financial audits are performed periodically by Medicare from whom the agency received information through the common audit agreement.

## 5. Public Notice

42 CFR 447.253(h)

The reimbursement methodology change for inpatient hospital services has met the public notice requirements by publication in the Kansas Register.

## 6. Rates Paid

42 CFR 447.253(i)

The State assures that the Medicaid agency pays for inpatient hospital services using rates determined in accordance with methods and standards specified in an approved State plan.

Refers to MS-95-21

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7. Related Information

42 CFR 447.255

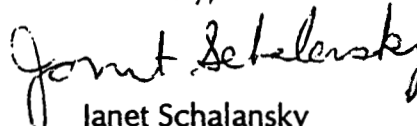
The average payment rate is expected to be \$3,200 per discharge in FFY 1996. This is an increase about 1% from FFY 1995 primarily due to continued reductions in length of stay. Most hospitals received increases in their base payment rates.

Considering the estimated cost of the inpatient portion of allowances and discounts, as well as the cost of Medicaid/MediKan services, over 95% of cost is expected to be reimbursed by Medicaid, MediKan and disproportionate share payments. This is based on the best information available from the Medicare cost reports and Medicaid/MediKan paid claims.

Both the short-term and long-term effect of these changes are estimated:

1. To maintain the availability on a statewide and geographic area basis;
2. To maintain the type of care furnished;
3. To maintain the extent of provider participation; and
4. To increase the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

Sincerely,

  
Janet Schalansky  
Deputy Secretary

JKS:AEK:mas

cc: Jim Nash